

<i>SERFF Tracking Number:</i>	<i>MDIC-126453857</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Medico Insurance Company</i>	<i>State Tracking Number:</i>	<i>44561</i>
<i>Company Tracking Number:</i>	<i>AR A20F MIPPA</i>		
<i>TOI:</i>	<i>MS08I Individual Medicare Supplement -</i>	<i>Sub-TOI:</i>	<i>MS08I.005 Plan F (Basic) 2010</i>
	<i>Standard Plans 2010</i>		
<i>Product Name:</i>	<i>AR A20F MIPPA</i>		
<i>Project Name/Number:</i>	<i>AR A20F MIPPA/LM AR A20F MIPPA</i>		

Filing at a Glance

Company: Medico Insurance Company

Product Name: AR A20F MIPPA

TOI: MS08I Individual Medicare Supplement -
Standard Plans 2010

Sub-TOI: MS08I.005 Plan F (Basic) 2010

Filing Type: Form/Rate

SERFF Tr Num: MDIC-126453857 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 44561

Co Tr Num: AR A20F MIPPA

State Status: Approved-Closed

Reviewer(s): Stephanie Fowler

Author: Luanne Melies

Disposition Date: 02/24/2010

Date Submitted: 01/13/2010

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date: 06/01/2010

State Filing Description:

General Information

Project Name: AR A20F MIPPA

Project Number: LM AR A20F MIPPA

Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments: Not filed with
Nebraska, our state of domicile, at this time.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 02/24/2010

Explanation for Other Group Market Type:

State Status Changed: 02/24/2010

Deemer Date:

Created By: Luanne Melies

Submitted By: Luanne Melies

Corresponding Filing Tracking Number: MDIC-
126453783 Plan A, MDIC-126453841 Plan D,
MDIC-126453857 Plan F

Filing Description:

Filing of Individual Medicare Supplement Plans A, D and F for MIPPA 2010. Please refer to the attached cover letter for
form number identification and other filing details

MDIC-126453783 Plan A

MDIC-126453841 Plan D

SERFF Tracking Number: MDIC-126453857 State: Arkansas
Filing Company: Medico Insurance Company State Tracking Number: 44561
Company Tracking Number: AR A20F MIPPA
TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.005 Plan F (Basic) 2010
Standard Plans 2010
Product Name: AR A20F MIPPA
Project Name/Number: AR A20F MIPPA/LM AR A20F MIPPA

MDIC-126453857 Plan F

Company and Contact

Filing Contact Information

Luanne Melies, Compliance Analyst
1515 S. 75th Street
Omaha, NE 68124
Imelies@gomedico.com
800-695-5976 [Phone] 249 [Ext]
402-391-4858 [FAX]

Filing Company Information

Medico Insurance Company
1515 S. 75th Street
Omaha, NE 68124
(800) 695-5976 ext. [Phone]
CoCode: 31119
Group Code:
Group Name: Medico
FEIN Number: 47-0122200
State of Domicile: Nebraska
Company Type: Life and Health
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation: One Policy with Associated Forms @ \$50.00
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Medico Insurance Company	\$50.00	01/13/2010	33487303

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	02/24/2010	02/24/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Outline of Coverage	Luanne Melies	02/18/2010	02/18/2010
Supporting Document	Application	Karl Hug	02/09/2010	02/09/2010
Supporting Document	Outline of Coverage	Karl Hug	02/09/2010	02/09/2010

<i>SERFF Tracking Number:</i>	<i>MDIC-126453857</i>	<i>State:</i>	<i>Arkansas</i>
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<i>Product Name:</i>	<i>AR A20F MIPPA</i>		
<i>Project Name/Number:</i>	<i>AR A20F MIPPA/LM AR A20F MIPPA</i>		

Disposition

Disposition Date: 02/24/2010

Implementation Date: 06/01/2010

Status: Approved-Closed

Comment: This 2010 Plan filing has been approved; please note that any current plans not re-filed to be compliant with the recent changes set to be effective June 1, 2010 will be considered as withdrawn from the market and will not be allowed for a period of five years.

Rate data does NOT apply to filing.

SERFF Tracking Number:	MDIC-126453857	State:	Arkansas
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Company Tracking Number:	AR A20F MIPPA		
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Product Name:	AR A20F MIPPA		
Project Name/Number:	AR A20F MIPPA/LM AR A20F MIPPA		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document (revised)	Application	Approved	Yes
Supporting Document	Application	Replaced	Yes
Supporting Document	Health - Actuarial Justification	Accepted for Informational Purposes	No
Supporting Document (revised)	Outline of Coverage	Approved	Yes
Supporting Document	Outline of Coverage	Replaced	Yes
Supporting Document	Outline of Coverage	Replaced	Yes
Supporting Document	MI9F-4218	Accepted for Informational Purposes	Yes
Supporting Document	MI9F-2701(AR)	Accepted for Informational Purposes	Yes
Supporting Document	MIR-AR-763	Accepted for Informational Purposes	Yes
Supporting Document	AR Cover Letter	Accepted for Informational Purposes	Yes
Form	Medicare Supplement Policy Plan F	Approved	Yes
Form	Policy Schedule Page for Plan F	Approved	Yes
Form	Replacement Notice	Approved	Yes
Form	Benefit Notice for Plan F	Approved	Yes
Rate	A20 Rate Sheets	Approved	Yes

SERFF Tracking Number: MDIC-126453857 *State:* Arkansas
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Standard Plans 2010
Product Name: AR A20F MIPPA
Project Name/Number: AR A20F MIPPA/LM AR A20F MIPPA

Amendment Letter

Submitted Date: 02/18/2010

Comments:

Premium Amounts are now bracketed.

Thank you for your help with this filing.

Changed Items:

Supporting Document Schedule Item Changes:

Satisfied -Name: Outline of Coverage

Comment: We have revised this form. Minor changes were made on page 2, regarding Credit/Debit Card transactions and the factors table.

Premium Amounts are now bracketed.

MI9F-4363(AR)-B-02042010.pdf

SERFF Tracking Number: MDIC-126453857 State: Arkansas
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Company Tracking Number: AR A20F MIPPA
TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.005 Plan F (Basic) 2010
Standard Plans 2010
Product Name: AR A20F MIPPA
Project Name/Number: AR A20F MIPPA/LM AR A20F MIPPA

Amendment Letter

Submitted Date: 02/09/2010

Comments:

We have made minor changes to the two attached forms. Please see "comments" for the details of these changes, thank you.

Changed Items:

Supporting Document Schedule Item Changes:

Satisfied -Name: Application

Comment: We have revised this form. Minor changes were made to page 4, regarding Credit/Debit Card transactions. MIHAA20(AR)-B-02042010.pdf

Satisfied -Name: Outline of Coverage

Comment: We have revised this form. Minor changes were made on page 2, regarding Credit/Debit Card transactions and the factors table.

MI9F-4363(AR)-B-02042010.pdf

SERFF Tracking Number: MDIC-126453857 State: Arkansas

Filing Company: Medico Insurance Company State Tracking Number: 44561

Company Tracking Number: AR A20F MIPPA

TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.005 Plan F (Basic) 2010
Standard Plans 2010

Product Name: AR A20F MIPPA

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Form Schedule

Lead Form Number: MI-MSA20F(AR)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 02/24/2010	MI-MSA20F(AR)	Policy/Contract	Cont Medicare Supplement Policy Plan F Certificate	Initial			MI-MSA20F(AR)-09082009.pdf
Approved 02/24/2010	POLICY A20[F]	Schedule Pages	Policy Schedule Page for Plan F	Initial			A20(F)10152009.pdf
Approved 02/24/2010	MI9F-4368	Other	Replacement Notice	Initial			MI9F-4368-09222009.pdf
Approved 02/24/2010	MI9F-4367F	Other	Benefit Notice for Plan F	Initial			MI9F-4367F-09092009.pdf



MEDICO®
INSURANCE COMPANY

A STOCK INSURANCE COMPANY

1515 South 75th Street • Omaha, Nebraska 68124 • 1-800-228-6080

MEDICARE SUPPLEMENT INSURANCE POLICY

This policy is a legal contract between you and us. **READ YOUR POLICY CAREFULLY.** Also, read the copy of your application and the policy Schedule. If there is any error or omission, tell us. We will make any needed change.

The first premium you, the Insured, paid before the Policy Date (and the copy of your attached application), put this policy in force as of the Policy Date. That date is shown in the Schedule. The Schedule is attached and is a part of this policy.

PART A PLEASE READ — 30-DAY RIGHT TO RETURN

Please read your policy. If you are not satisfied, send it back to us, or to the Producer who sold it to you, within 30 days after you receive it. We will return your money. That will mean your policy was never in force. Any refund made pursuant to this section will be paid directly to you in a timely manner.

PART B GUARANTEED RENEWABLE SUBJECT TO OUR LIMITED RIGHT TO CHANGE PREMIUMS

We guarantee to renew your policy for life as long as the premium is paid within the allowable time. We cannot make a change in your policy without your consent. We do have the right to change your premium as stated below.

Premium Change: We may change the premium rates for this policy. The change may be due to a change in policy coverage or a new table of rates. We can change your premium only if we do the same to all policies of this form issued to persons of your class. "Class" means the factors of underwriting class and geographic area of your state of residence that determined your premium rate when coverage was issued. If we make a change, it will not be based on any physical impairment you might have or any claims you have incurred under this policy. If it is necessary to change the premium for your policy, we will notify you in advance of the change in premium.

PART C COVERAGE CHANGE

Automatic Change In Coverage: Policy benefits that are designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may change to correspond with these changes.

Insuring Clause: We agree to provide the benefits set out in this policy for any insured loss. This agreement is subject to all of the provisions of the policy. A "loss" is an expense you incur for care or services this policy covers and that you receive after the Policy Date and while the policy is in force.

Notice to buyer: This policy may not cover all of your medical expenses.

MEDICARE SUPPLEMENT POLICY BENEFIT PLAN F

ALPHABETICAL GUIDE TO YOUR POLICY

	Part		Part
Benefits	F & G	Payment Of Claims	L
Coverage Change	C	Renewal Agreement And Premium Change	B
Definitions	E	Right To Return.....	A
Exceptions	D	Schedule	Last Page
Extension Of Benefits	H	Suspension Of Premiums And Coverage	I
How To File A Claim	K	Termination	J
Other Important Provisions	M		

PART D

EXCEPTIONS

We will NOT pay benefits for:

1. any expense incurred for outpatient prescription drugs, other than drugs covered by Medicare Parts A and B;
2. non-Medicare Eligible Expenses, including, but not limited to: routine exams, take-home drugs and eye refractions;
3. services for which you are not liable or for which no charge normally is made in the absence of insurance; and
4. loss that occurs while this policy is not in force.

Nonduplication: This policy will not duplicate any benefit paid by Medicare.

PART E

DEFINITIONS

Benefit Period: The period of time defined by Medicare as a Benefit Period.

Calendar Year: Begins on January 1 and ends on December 31.

Hospice Care: A program of palliative care approved for payment by Medicare that provides for the physical, emotional and spiritual care needs of a terminally ill patient and his or her family.

Injury: Accidental bodily Injury that results in loss, independent of Sickness or other causes.

Medicaid: The "Health Insurance for the Aged Act," Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare: The "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare Eligible Expenses: Expenses eligible for coverage by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

Physician: A licensed practitioner of the healing arts acting within the scope of his/her license.

Policy Date: The date on which this policy first became effective. That date is shown on the Schedule.

Policy Renewal Date: The month and day your policy's premium is due. The frequency of the Policy Renewal Date can vary depending on the premium payment option you selected. This is shown on the Schedule.

Producer: A person required to be licensed under the laws of the state to sell, solicit or negotiate insurance.

Respite Care: Hospice Care services provided by the Hospice Care program to give temporary relief to a hospice patient's family or other caregivers.

Schedule: Is attached to and is a part of this policy.

Sickness: An illness or disease that you have or acquire.

We, Us or Our: Medico Insurance Company.

You or Your: The Insured named in the Schedule.

PART F BASIC BENEFITS

We will pay benefits for the following expenses you incur.

1. Medicare Part A Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st through 90th day in any Medicare Benefit Period.
2. Medicare Part A Eligible Expenses for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.
3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable Prospective Payment System (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider must accept our payment as payment in full and may not bill you for any balance.
4. Under Medicare Parts A and B, the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells as defined under federal regulations) unless replaced in accordance with federal regulations.
5. The coinsurance amount, or in the case of hospital outpatient department services paid under a Prospective Payment System, the copayment amount, of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible. In all cases involving hospital outpatient department services paid under a Prospective Payment System, the issuer is required to pay the copayment amount established by the Center for Medicaid and Medicare Services (CMS), which will be either the amount established for the Ambulatory Payment Classification (APC) Group, or a provider-elected reduced copayment amount.
6. Hospice Care: Coverage of cost sharing for all Medicare Part A Eligible Expenses for Hospice Care and Respite Care.

PART G ADDITIONAL BENEFITS

We will pay benefits for the following expenses you incur. If you are not enrolled in Part B of Medicare, the benefits that supplement Part B of Medicare will be paid as if you were enrolled and Medicare paid benefits.

1. **Medicare Part A Deductible.** The Medicare Part A inpatient hospital deductible amount per Benefit Period.
2. **Skilled Nursing Facility Care.** The actual billed charge, up to the coinsurance amount, from the 21st day through the 100th day in a Medicare Benefit Period for posthospital skilled nursing facility care eligible under Medicare Part A.
3. **Medicare Part B Deductible.** The Medicare Part B deductible amount per Calendar Year, regardless of hospital confinement.
4. **Medicare Part B Excess Charges.** 100% of the Medicare Part B excess charges. This is the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

5. **Medically Necessary Emergency Care in a Foreign Country.** To the extent not covered by Medicare, 80% of the billed charges for Medicare Eligible Expenses for medically necessary emergency hospital, Physician and medical care received in a foreign country, subject to the following limitations:
- a. such care would have been covered by Medicare if provided in the United States;
 - b. such care began during the first 60 consecutive days of each trip outside the United States;
 - c. benefits are subject to a \$250 Calendar Year deductible; and
 - d. benefits are subject to a lifetime maximum benefit of \$50,000.

For this benefit, **Emergency Care** means care needed immediately because of an Injury or Sickness of sudden and unexpected onset.

PART H EXTENSION OF BENEFITS

Termination of coverage shall be without prejudice to a continuous loss which commenced while your policy was in force. Extension of benefits beyond the period this policy was in force is:

1. subject to your continuous total disability;
2. limited to those conditions which caused the continuous loss beginning while this policy was in force; and
3. limited to the duration benefits would have been paid had your policy continued in force or payment of the maximum benefits.

Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

PART I SUSPENSION OF PREMIUMS AND COVERAGE

The benefits and premiums of this policy will be suspended at your request for the period, not to exceed 24 months, in which you have applied for and are determined to be entitled to medical assistance under the Medicaid program. We must receive your written notice within 90 days after the date you become entitled to this assistance. Upon our receipt of timely notice, we will return that portion of the premium paid for the period of time you are eligible for Medicaid. Your refunded premium will be reduced by the amount of any claims paid for the period.

If you lose entitlement to this medical assistance after suspension occurs, your policy will be reinstituted automatically, effective as of the date the entitlement to medical assistance terminated. We must receive your written notice of the loss of the entitlement within 90 days after the date you lose the entitlement. Your notice and payment of the required premium will put the policy back in force.

The benefits and premiums of this policy will also be suspended at your request (for any period that may be provided by federal regulation) if you are entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan. We must receive your written notice within 90 days after the date you become covered under the group health plan. Upon our receipt of timely notice, we will return that portion of the premium paid for the period of time you are covered under the group health plan. Your refunded premium will be reduced by the amount of any claims paid for the period.

If you lose coverage under the group health plan after suspension occurs, your policy will be reinstituted automatically, effective as of the date the coverage ended. We must receive your written notice of the loss of coverage within 90 days after the coverage ends.

Reinstitution of your policy after either suspension will:

1. not provide an additional waiting period with regard to pre-existing conditions;
2. be substantially equivalent to what it was before the date of suspension; and
3. provide for a premium class that is as favorable to you as it would have been if the coverage had not been suspended.

PART J

TERMINATION

Your policy will terminate on the earliest of:

1. the Policy Renewal Date following the date we receive your written or verbal request to cancel the policy, unless you request a later termination date (the grace period will not apply);
2. the Policy Renewal Date if sufficient premium has not been paid before the end of the grace period; or
3. the date of your death.

In the event of your death, we will promptly return the unearned portion of any premium paid beyond the date of death.

Termination of coverage will not affect any claim originating while your policy was in force.

PART K

HOW TO FILE A CLAIM

Notice of Claim: You must give us written notice of a claim within 20 days after loss starts or as soon as reasonably possible. You may give the notice or you may have someone do it for you. The notice should give your name and policy number. Notice should be mailed to our Home Office in Omaha, Nebraska, or to one of our Producers.

Electronic Claim Filing Process: Your health care providers will usually submit electronically to Medicare the billed charges for any medical and hospital expenses you incur. Medicare then processes benefits for expenses eligible under Part A and/or Part B of Medicare, and passes your claim electronically to us for consideration of benefits under your Medicare supplement policy. We will accept Medicare's electronic submission of your claim to us as your notice of claim. For consideration of expenses that are not submitted electronically to us, a paper copy of your Medicare Summary Notice or Medicare Benefit Notice can serve as your notice of claim. This Medicare statement shows your Medicare Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of your Medicare statement to us or your health care provider may submit it to us on your behalf. If your claim is submitted electronically the requirements for claim forms and proof of loss will be met.

Claim Forms: When we receive your notice of claim, we will send you forms for filing proof of loss. If these forms are not sent to you within 15 days, you will have met the proof of loss rule below if you give us a written statement within 90 days after the loss began.

Proof of Loss: You must give us written proof of your loss within 90 days or as soon as reasonably possible. Proof must be furnished within 15 months after loss began, except in the absence of legal capacity.

PART L

PAYMENT OF CLAIMS

Time of Payment of Claims: All benefits will be paid immediately upon receipt of due written proof of loss.

Payment of Claims: Subject to your written direction in the application or otherwise, all or a portion of any benefits provided by this policy due to hospital, nursing, medical or surgical services may, at our option and unless you request otherwise in writing not later than the time of filing proof of such loss, be paid directly to the hospital or person rendering such services. It is not required that the services be rendered by a particular hospital or person.

Benefits unpaid at your death will be paid to your beneficiary or your estate. If any benefit is payable to your estate, to a minor or to any person not able to give a valid release, we may pay up to \$1,000 (\$5,000 in Nebraska) to any relative of yours by blood or connection by marriage, or any beneficiary that we find entitled to the payment. Any payment we make in good faith will fully discharge us to the extent of the payment.

Entire Contract; Changes: This policy, with any attachments (and the copy of your application), is the entire contract of insurance. No Producer may make contracts, determine insurability or change the application or policy in any way. Only an executive officer of ours can approve a change. That change must be shown in the policy.

Time Limit on Certain Defenses: After three years from the Policy Date, no misstatements, except fraudulent misstatements in the application for the policy, can be used to void the policy or to deny a claim for loss incurred or disability commencing after the expiration of such three-year period.

Pre-Existing Conditions: We will not reduce or deny a claim under this policy because a Sickness or Injury existed before the Policy Date.

Grace Period: Your premium must be paid on or before the date it is due or during the 31-day grace period that follows. Your policy stays in force during your grace period.

Reinstatement: Your policy will lapse if you do not pay your premium before the end of the grace period. If we later accept a premium and do not require an application for reinstatement, that payment will put this policy back in force. If we require an application for reinstatement and, as may be needed, issue a conditional receipt, this policy will be put back in force when we approve it. If we fail to notify you of disapproval within 45 days of the date of application (or the date of the conditional receipt, where that is required), your policy will be put back in force on that 45th day.

Your reinstated policy will cover only loss due to Injuries received or Sickness that begins after the date your policy was put back in force.

In all other respects, you and we will have the same rights under this policy that we had before it lapsed. The premium we accept to reinstate this policy may be used for a period for which premiums had not been paid, but it will not be used for any period more than 60 days before the reinstatement date.

Physical Examination: We, at our expense, can have you examined as often as reasonably needed while a claim is pending.

Legal Action: You cannot bring a legal action to recover under your policy for at least 60 days after you have given us written proof of loss. You cannot start such an action more than three years after the date written proof of loss is required.

Change of Beneficiary; Assignment: Only you have the right to change the beneficiary. This right is yours unless you make a beneficiary designation that may not be changed. Consent of the beneficiary is not required to make a change in this policy. Also, such consent is not required to surrender this policy or to assign the benefits.

Refund of Unearned Premium: In the event of your death, we will promptly return the unearned portion of any premium paid beyond the end of the policy month in which your death occurred.

Other Insurance with Us: You may have only one policy like this one with us at any one time. If you have more than one such policy, the one you, your beneficiary or your estate selects will remain in force. We will return all premiums paid for all other such policies.

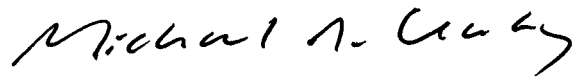
Term of Coverage: Your coverage starts on the Policy Date at 12:01 a.m. standard time where you live. It ends at 12:01 a.m. on the same standard time on the first Policy Renewal Date. Each time you renew your policy, the new term begins when the old term ends.

Conformity With State Statutes: The provisions of the policy must conform with the laws of the state in which you reside on the Policy Date. If any do not, this clause amends them so that they do conform.

Our President and Secretary sign this policy in our behalf.

A handwritten signature in black ink, appearing to read "Justin Gray", written in a cursive style.

President

A handwritten signature in black ink, appearing to read "Michael A. Gray", written in a cursive style.

Secretary

MEDICO INSURANCE COMPANY
1515 SOUTH 75TH STREET
OMAHA, NEBRASKA 68124

SCHEDULE

POLICY NO. - [0000000]

POLICY TYPE – A20[F]

INSURED - [JOHN E. DOE]
[1234 ANY STREET]
[ANYTOWN, USA 00000]

----- POLICY PREMIUMS -----
[MODE\$ [XXX.XX]

POLICY DATE [07/01/10]
FIRST RENEWAL DATE [07/01/11]
TOTAL FIRST PREMIUM \$ [XXXX.XX]
AGE AT ISSUE [65]

POLICY A20[F]

Replacement Notice

**NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR
MEDICARE ADVANTAGE**

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application or information you have furnished, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by Medico Insurance Company. Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that the purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER OR PRODUCER:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason. (Check One):

- ☐ Additional benefits.
- ☐ No change in benefits, but lower premiums.
- ☐ Fewer benefits and lower premiums.
- ☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- ☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment below.
- ☐ Other. (please specify)

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Producer

Typed Name and Address of Issuer or Producer

Applicant's Signature

Date

Medicare Supplement Notice

NOTICE ON CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT INSURANCE

The following outline briefly describes the modifications in Medicare and in your Medicare supplement coverage. Please read carefully!

Services	Medicare Benefits - Effective [June 1, 2010] Medicare will pay	Your Medicare Supplement Coverage - Effective [June 1, 2010] MSA20F will pay
MEDICARE PART A SERVICES AND SUPPLIES		
Inpatient Hospital Benefits		
First 60 Days	All but [\$1,100]	[\$1,100]
61 st to 90 th Day	All but [\$275] a day	[\$275] a day
91 st to 150 th Day	All but [\$550] a day	[\$550] a day
151 st Day for an Additional 365 Days	\$0	100% of Medicare eligible expenses
Skilled Nursing Facility Care (if Medicare-Approved)		
First 20 Days	All approved amounts	\$0
21 st to 100 th Day	All but [\$137.50] a day	Up to [\$137.50] a day
After 100 Days	\$0	\$0
Hospice Care (must meet Medicare's certification requirements)	All but very limited copayment & coinsurance for outpatient drugs & inpatient respite care	Medicare copayment and coinsurance
MEDICARE PART B SERVICES AND SUPPLIES		
Medical Expenses		
*First [\$155] of Medicare-Approved Amounts	\$0	[\$155]
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	100%
Blood		
First 3 Pints	\$0	All costs
*Next [\$155] of Medicare-Approved Amounts	\$0	[\$155]
Remainder of Medicare-Approved Amounts	80%	20%

(over)

MEDICARE PARTS A AND B SERVICES AND SUPPLIES		
Home Health Care (if Medicare-Approved) –		
Medically necessary skilled care services and medical supplies	100%	\$0
Durable Medical Equipment:		
*First [\$155] of Medicare-Approved Amounts	\$0	[\$155]
Remainder of Medicare-Approved Amounts	80%	20%

* This is the Part B deductible, and only needs to be met once per calendar year.

If it is necessary to change the premium for your policy, we will notify you in advance of the change in premium.

THIS CHART SUMMARIZING THE CHANGES IN YOUR MEDICARE BENEFITS AND IN YOUR MEDICARE SUPPLEMENT PROVIDED BY MEDICO® INSURANCE COMPANY ONLY BRIEFLY DESCRIBES SUCH BENEFITS. FOR INFORMATION ON YOUR MEDICARE BENEFITS CONTACT YOUR SOCIAL SECURITY OFFICE OR THE CENTERS FOR MEDICARE & MEDICAID SERVICES. FOR INFORMATION ON YOUR MEDICARE SUPPLEMENT POLICY CONTACT MEDICO INSURANCE COMPANY AT 1515 SOUTH 75TH STREET, OMAHA, NE 68124, OR CONTACT THE PRODUCER WHO SOLD YOU THE POLICY.

<i>SERFF Tracking Number:</i>	<i>MDIC-126453857</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Medico Insurance Company</i>	<i>State Tracking Number:</i>	<i>44561</i>
<i>Company Tracking Number:</i>	<i>AR A20F MIPPA</i>		
<i>TOI:</i>	<i>MS08I Individual Medicare Supplement - Standard Plans 2010</i>	<i>Sub-TOI:</i>	<i>MS08I.005 Plan F (Basic) 2010</i>
<i>Product Name:</i>	<i>AR A20F MIPPA</i>		
<i>Project Name/Number:</i>	<i>AR A20F MIPPA/LM AR A20F MIPPA</i>		

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate Action Information:	Attachments
Approved 02/24/2010	A20 Rate Sheets	MI-MSA20A(AR), New MI-MSA20D(AR), MI-MSA20F(AR)			AR_A20_I_RateS chd_20091022.p df

Medico™ Insurance Company
Omaha, Nebraska
MI-MSA20A
Gross Premium Code: A10AH - Rate Group: A10
Standardized Medicare Supplement Plan A - Community Rated

RATE SCHEDULE - Arkansas
For Issues Beginning 06/01/2010

Issue Age	Plan A	Plan A
	Standard Premium	Preferred Premium
65 & OV	1,649.28	1,434.96

AREA FACTORS
by Zip Code (First three positions)
716, 720, 721, 722, 723 = 0.80
717, 718, 719, 724 = 0.71
725, 726, 727, 728, 729 = 0.71

MODAL FACTORS

Direct-Billed
Annual = 1.00
Semi-Annual = 0.52
Quarterly = 0.27
Bi-Monthly = 2/11
Monthly = 1/11

Automatic Bank Withdrawal
Annual = 1.00
Semi-Annual = 0.52
Quarterly = 3/12
Bi-Monthly = 2/12
Monthly = 1/12

Rates certify to a 74.4% anticipated loss ratio.

MIRSA20A(AR) 6/10

Medico™ Insurance Company
Omaha, Nebraska
MI-MSA20D
Gross Premium Code: A10DH - Rate Group: A10
Standardized Medicare Supplement Plan D - Community Rated

RATE SCHEDULE - Arkansas
For Issues Beginning 06/01/2010

Issue Age	Plan D	Plan D
	Standard Premium	Preferred Premium
65 & OV	2,288.88	1,991.28

AREA FACTORS
by Zip Code (First three positions)
716, 720, 721, 722, 723 = 0.80
717, 718, 719, 724 = 0.71
725, 726, 727, 728, 729 = 0.71

MODAL FACTORS

Direct-Billed
Annual = 1.00
Semi-Annual = 0.52
Quarterly = 0.27
Bi-Monthly = 2/11
Monthly = 1/11

Automatic Bank Withdrawal
Annual = 1.00
Semi-Annual = 0.52
Quarterly = 3/12
Bi-Monthly = 2/12
Monthly = 1/12

Rates certify to a 74.4% anticipated loss ratio.

MIRSA20D(AR) 6/10

Medico™ Insurance Company
Omaha, Nebraska
MI-MSA20F
Gross Premium Code: A10FH - Rate Group: A10
Standardized Medicare Supplement Plan F - Community Rated

RATE SCHEDULE - Arkansas
For Issues Beginning 06/01/2010

Issue Age	Plan F	Plan F
	Standard Premium	Preferred Premium
65 & OV	2,462.64	2,142.48

AREA FACTORS
by Zip Code (First three positions)
716, 720, 721, 722, 723 = 0.80
717, 718, 719, 724 = 0.71
725, 726, 727, 728, 729 = 0.71

MODAL FACTORS

Direct-Billed
Annual = 1.00
Semi-Annual = 0.52
Quarterly = 0.27
Bi-Monthly = 2/11
Monthly = 1/11

Automatic Bank Withdrawal
Annual = 1.00
Semi-Annual = 0.52
Quarterly = 3/12
Bi-Monthly = 2/12
Monthly = 1/12

Rates certify to a 74.4% anticipated loss ratio.

MIRSA20F(AR) 6/10

Medico™ Insurance Company
Omaha, Nebraska
MI-MSA10, MI-MSA11, MI-MSA20, MI-MSA21
Area Factors

State	Zip	Factor
AK	All	0.83
AL	All	0.81
AR	716, 720-723	0.80
	717-719, 724-729	0.71
AZ	850	0.81
	852-853, 855-857, 859-865	0.69
CA	All	0.92
CO	800-802, 804, 806	0.82
	803, 805, 807-816	0.78
CT	All	0.91
DC	All	0.92
DE	All	0.84
FL	All	1.04
GA	All	0.78
HI	All	0.57
IA	500-505, 508-514, 520-528	0.66
	506-507, 515-516	0.75
ID	All	1.00
IL	600-608	0.89
	609-620, 622-629	0.71
IN	460-462, 465-479	0.76
	463-464	0.88
KS	All	0.78
KY	400-401, 403-404, 406-407, 409-414, 419-427	0.77
	402, 405, 408	0.81
	415-418	0.96
LA	All	1.00
MA	All	0.93
MD	All	0.95
ME	All	0.71
MI	All	0.90
MN	All	0.71
MO	630, 633, 640-641	0.88
	634, 648-658	0.72
	635-639, 644-647	0.81
MS	All	0.84
MT	All	0.65
NC	All	0.76

State	Zip	Factor
ND	All	0.67
NE	680-681, 685	0.75
	683-684, 686-693	0.68
NH	All	0.73
NJ	All	0.98
NM	870, 873, 875, 877-878, 880	0.66
	871-872, 874, 879, 881-884	0.74
NV	889, 893-895, 897-898	0.76
	890-891	0.95
NY	All	0.98
OH	All	0.83
OK	730, 735-741, 743-744, 746, 748, 749	0.81
	731, 734, 745, 747	0.89
OR	970-975	0.69
	976-979	0.65
PA	150-154, 156	0.96
	155, 157-188, 195-196	0.78
	189-194	1.01
RI	All	0.85
SC	290-293, 296-299	0.75
	294-295	0.79
SD	All	0.67
TN	All	0.81
TX	733, 751, 758, 760, 764, 774, 779-782, 787, 795, 797	0.89
	750, 754-757, 759, 761, 763, 765-767, 773	0.94
	752-753, 770, 772, 775-777, 783-784, 793-794	1.00
	762, 768, 778, 786, 789, 792	0.85
	769, 788, 790-791, 796, 798-799, 885	0.78
	785	1.26
UT	All	0.73
VA	201, 221, 224-232, 236, 238-241, 243-245	0.69
	220, 222-223, 233-235, 237, 242, 246	0.80
VT	All	0.69
WA	All	0.72
WI	All	0.69
WV	All	0.73
WY	All	0.69

<i>SERFF Tracking Number:</i>	<i>MDIC-126453857</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Medico Insurance Company</i>	<i>State Tracking Number:</i>	<i>44561</i>
<i>Company Tracking Number:</i>	<i>AR A20F MIPPA</i>		
<i>TOI:</i>	<i>MS08I Individual Medicare Supplement - Standard Plans 2010</i>	<i>Sub-TOI:</i>	<i>MS08I.005 Plan F (Basic) 2010</i>
<i>Product Name:</i>	<i>AR A20F MIPPA</i>		
<i>Project Name/Number:</i>	<i>AR A20F MIPPA/LM AR A20F MIPPA</i>		

Supporting Document Schedules

	Item Status:	Status
		Date:
Satisfied - Item: Flesch Certification	Accepted for Informational Purposes	02/24/2010
Comments:		
Attachment:		
AR Flesch Certificate MIPPA.pdf		

	Item Status:	Status
		Date:
Satisfied - Item: Application	Approved	02/24/2010
Comments:		
We have revised this form. Minor changes were made to page 4, regarding Credit/Debit Card transactions.		
Attachment:		
MIHAA20(AR)-B-02042010.pdf		

	Item Status:	Status
		Date:
Satisfied - Item: Outline of Coverage	Approved	02/24/2010
Comments:		
We have revised this form. Minor changes were made on page 2, regarding Credit/Debit Card transactions and the factors table.		
Premium Amounts are now bracketed.		
Attachment:		
MI9F-4363(AR)-B-02042010.pdf		

	Item Status:	Status
		Date:
Satisfied - Item: MI9F-4218	Accepted for Informational Purposes	02/24/2010
Comments:		

SERFF Tracking Number: MDIC-126453857 State: Arkansas
 Filing Company: Medico Insurance Company State Tracking Number: 44561
 Company Tracking Number: AR A20F MIPPA
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.005 Plan F (Basic) 2010
 Standard Plans 2010
 Product Name: AR A20F MIPPA
 Project Name/Number: AR A20F MIPPA/LM AR A20F MIPPA

The medical authorization MI9F-4218 will be sent with the application to obtain medical authorization from the applicant. This HIPAA Compliant Medical Authorization form is enclosed for informational purposes only.

Attachment:

MI9F-4218-11262007.pdf

	Item Status:	Status Date:
Satisfied - Item: MI9F-2701(AR)	Accepted for Informational Purposes	02/24/2010

Comments:

The Guaranty Association Notice MI9F-2701(AR) will be delivered with the policy. This form received approval by your division on April 21, 2008 under Serff Filing MDIC-125606274 and is enclosed here for informational purposes, only

Attachment:

MI9F-2701(AR)-07012007.pdf

	Item Status:	Status Date:
Satisfied - Item: MIR-AR-763	Accepted for Informational Purposes	02/24/2010

Comments:

The Toll-Free Customer Service Notice, MIR-AR-763 will be delivered with the policy, as required by law. Form MIR-AR-763 was previously approved by your Department on October 27, 2009 under Serff Filing MDIC-126340784. This form is enclosed here for informational purposes only.

Attachment:

MIR-AR-763-10122009.pdf

	Item Status:	Status Date:
Satisfied - Item: AR Cover Letter	Accepted for Informational Purposes	02/24/2010

Comments:

Attachment:

AR-A20 Cover Letter.pdf

FLESCH READABILITY CERTIFICATION

Form Number MI-MSA20A(AR) has been Flesch tested.
The Flesch Readability Score was computed to be 49.6.

Form Number MI-MSA20D(AR) has been Flesch tested.
The Flesch Readability Score was computed to be 48.1.

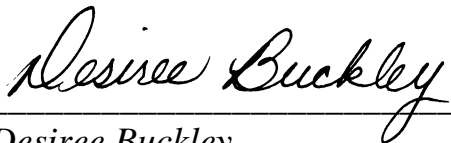
Form Number MI-MSA20F(AR) has been Flesch tested.
The Flesch Readability Score was computed to be 48.9.

Form Number MI9F-4363(AR) has been Flesch tested.
The Flesch Readability Score was computed to be 42.5.

Form Number MI9F-4368 has been Flesch tested.
The Flesch Readability Score was computed to be 41.2.

Form Number MI9F-4367[A, D & F] have been Flesch tested.
The Flesch Readability Score was computed to be 42.2.

MEDICO INSURANCE COMPANY



Desiree Buckley

Vice President / Director of Compliance



Toll-Free 1-800-228-6080

Application for Medicare Supplement Insurance

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Part A: General Information – Please Print

Name	Date of Birth Mo./Day/Yr.	Age	Sex	Height	Weight
------	------------------------------	-----	-----	--------	--------

Address _____
 Street Address City State Zip

Phone #	E-mail Address
---------	----------------

Social Security # Medicare Claim #

Beneficiary (Optional) _____ Relationship _____

Beneficiary's Address			
Street Address	City	State	Zip

Best time to call for Personal Health Interview

Are you eligible for Open Enrollment? ☐ Yes ☐ No If "Yes," we will need documentation, unless you are turning 65.

Part B: Insurance Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application.

Please answer the following questions to the best of your knowledge.

1. (a) Did you turn age 65 in the last 6 months? ☐ Yes ☐ No
(b) Did you enroll in Medicare Part B in the last 6 months? ☐ Yes ☐ No
(c) If "Yes," what is the effective date? _____
2. Are you insured under Parts A and B of Medicare? (If "No," you are not eligible for coverage) ☐ Yes ☐ No
3. Are you covered for medical assistance through the state Medicaid program? (If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "No" to this question.) ☐ Yes ☐ No
If "Yes," (a) Will Medicaid pay your premiums for this Medicare supplement policy? ☐ Yes ☐ No
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B Premium? ☐ Yes ☐ No
4. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.
START _____ END _____
(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? ☐ Yes ☐ No
(c) Was this your first time in this type of Medicare plan? ☐ Yes ☐ No
(d) Did you drop a Medicare supplement policy to enroll in this Medicare plan? ☐ Yes ☐ No
5. (a) Do you have another Medicare supplement policy in force? ☐ Yes ☐ No
(b) If "Yes," with which company? _____
what plan?

Part B: Insurance Information (continued)

(c) If so, do you intend to replace your current Medicare supplement policy with this policy? ☐ Yes ☐ No

PRODUCER: If the answer to this question is yes, please complete and submit NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE.

6. Have you had coverage under any other health insurance within the past 63 days?
(For example, an employer, union or individual plan.) ☐ Yes ☐ No

(a) If "Yes," with which company? _____
what kind of policy? _____

(b) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.)

START _____ END _____

7. If you have lost or are losing other health insurance coverage, have you provided a copy of the notice from your prior insurer? ☐ Yes ☐ No

If "No," please provide an explanation. _____

Producer shall list any other health insurance policies he/she has sold to the applicant.

1) List policies you sold to the applicant that are still in force (If none, indicate "None"): ☐ None

Name of Insurer	Type	Policy #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2) List policies you sold to the applicant in the past five (5) years that are no longer in force (If none, indicate "None"): ☐ None

Name of Insurer	Type	Policy #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Producer: Is the insurance applied for intended to replace any medical or health insurance coverage? ☐ Yes ☐ No

Part C: Medical Information

NOTE: These questions should not be answered if you apply during "Open Enrollment" or if you are eligible for a guaranteed issue. If you answer "Yes," to any of questions 1 through 4 you are not eligible for coverage.

1. Have you ever:

(a) had any fractures due to osteoporosis or amputation due to disease? ☐ Yes ☐ No

(b) had kidney disease requiring dialysis; diabetes requiring insulin; Parkinson's disease; liver disease; or multiple or lateral sclerosis? ☐ Yes ☐ No

(c) been diagnosed with emphysema; chronic obstructive pulmonary disorder (COPD); or any other chronic pulmonary disorder? ☐ Yes ☐ No

(d) been treated for Alzheimer's disease; senile dementia; or organic brain disorder? ☐ Yes ☐ No

(e) had an organ transplant or been advised by a physician to have an organ transplant? ☐ Yes ☐ No

(f) had or been treated for Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No

Part C: Medical Information, continued

2. Within the past 24 months have you:

- (a) been hospitalized 3 or more times? ☐ Yes ☐ No
- (b) had a stroke or transient ischemic attack (TIA)? ☐ Yes ☐ No
- (c) been treated for or been diagnosed as having internal cancer; leukemia; or malignant melanoma? ☐ Yes ☐ No
- (d) had heart trouble or disease that required treatment by a physician (not including high blood pressure)? Taking prescription medication is not considered treatment. ☐ Yes ☐ No
- (e) been treated for alcohol or drug abuse; degenerative bone disease; crippling or rheumatoid arthritis; or been advised by a physician to have a joint replacement? ☐ Yes ☐ No

3. Within the past 12 months have you been advised that surgery for cataracts may be required? ☐ Yes ☐ No

4. Currently:

- (a) are you bedridden; confined (or has any doctor recommended that you be confined) to a hospital or nursing facility; or do you need the assistance of a walker or wheelchair? ☐ Yes ☐ No
- (b) do you have surgery pending or have you been advised to have surgery? ☐ Yes ☐ No

5. List all medications taken within the past 12 months (if none, indicate none).

Please provide the following information:

Medication				
Date originally prescribed				
Frequency and dosage				
Diagnosis/condition				

Part D: Preferred Rate Information

NOTE: This question should not be answered if you apply during "Open Enrollment" or if you are eligible for a guaranteed issue.

To qualify for preferred rates you must be able to answer "No" to the following question:

Have you used tobacco in the past 12 months? ☐ Yes ☐ No

Part E: Notices

You do not need more than one Medicare supplement policy.

If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility.

If you are eligible for, and have enrolled in, a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan.

Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

Part F: Benefit Options – Check the Plan you prefer:

☐ Policy Form MSA20A – Plan A

☐ Policy Form MSA20D – Plan D

☐ Policy Form MSA20F – Plan F

Make all checks payable to: Medico Insurance Company (do not make checks payable to the producer or leave payee line blank).

Note: If you select the Automatic Bank Withdrawal [or Credit/Debit Card] method of payment and we receive no money with your application, your first premium will be withdrawn from your account on the day we issue your policy.

Method of Payment:

☐ Automatic Bank Withdrawal

☐ Direct Bill

☐ Credit/Debit Card

Frequency of Payment:

☐ Monthly

☐ Quarterly

☐ Monthly

☐ Quarterly]

☐ Semi-Annually

☐ Quarterly

☐ Annually]

☐ Semi-Annually

☐ Annually]

Amount Received with Application \$ _____

Renewal Premium \$ _____

Effective Date of Policy _____
(Day after applicant signs the application or expiration date of current policy)

If you currently have health insurance in force, on what date does it end? _____

Part G: Application Agreement

I hereby apply for insurance to be issued solely and entirely upon the answers and statements in the Parts above that I adopt as my own and represent to be true, full and complete. I understand and agree that no insurance will be in force until coverage has been issued. If I am not applying during "Open Enrollment" or not eligible for a guaranteed issue, I do not have a right to have this policy issued to me if I have answered "Yes" to any of questions 1 through 4 in the Medical Information Part above. I have read, or had read to me, the complete application.

I have received the Notice of Privacy Practices and the Outline of Coverage for the policy.

Check one of the following if "A Guide to Health Insurance for People With Medicare" is required in the applicants' state:

- ☐ 1. I have agreed to accept a link to the Medicare Buyers Guide on the Company website at www.gomedico.com/products.
- ☐ 2. I have received a hard copy of the Medicare Buyers Guide.

I understand that it may be necessary to phone me to verify the answers to the questions in this application.

CAUTION: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or if the misrepresentation was material to our acceptance of the risk, rescind your policy.

Applicant's Signature _____ Date _____

Dated at _____
City State

Producer's Name _____
(Please print)

Producer's Signature _____ Date _____

Outline of Medicare Supplement Coverage – Benefit Plans A, D, and F

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

[Plans E, H, I and J are no longer available for sale.]

Basic Benefits:

- **Hospitalization** – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses** – Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood** – First three pints of blood each year.
- **Hospice** – Part A coinsurance.

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*		Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket \$[4620]; paid at 100% after limit reached	Out-of-pocket \$[2310]; paid at 100% after limit reached		

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [\$2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

PREMIUMS FOR MEDICARE SUPPLEMENT INSURANCE POLICY SERIES A20 – PLANS A, D AND F

Zip Codes: 716, 720, 721, 722 and 723

Issue Age	Preferred			Standard		
	Plan A	Plan D	Plan F	Plan A	Plan D	Plan F
65 & Over	[\$1,147.97]	[\$1,593.02]	[\$1,713.98]	[\$1,319.42]	[\$1,831.10]	[\$1,970.11]

Zip Codes: 717, 718, 719, 724, 725, 726, 727, 728 and 729

Issue Age	Preferred			Standard		
	Plan A	Plan D	Plan F	Plan A	Plan D	Plan F
65 & Over	[\$1,018.82]	[\$1,413.81]	[\$1,521.16]	[\$1,170.99]	[\$1,625.10]	[\$1,748.47]

*Premium rates shown above were approved in Arkansas on [July 1, 2009].

Premiums payable other than annual may be determined by the following factors:

	<u>[Monthly]</u>	<u>[Quarterly]</u>	<u>[Semi-Annual]</u>
[Automatic Bank Withdrawal:	1/12	0.25	N/A]
[Direct-Billed:	N/A	0.27	0.52]
[Credit/Debit Card:	1/12	0.27	0.52]

Premium Information

We, Medico Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this state.

Disclosures

Use this outline to compare benefits and premiums among policies.

[This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010, have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.]

Read Your Policy Very Carefully

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

Right To Return Policy

If you find that you are not satisfied with your policy, you may return it to 1515 South 75th Street, Omaha, NE 68124. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

Policy Replacement

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

Notice

This policy may not fully cover all of your medical costs.

Neither Medico Insurance Company nor its producers are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "The Medicare Handbook" for more details.

Complete Answers Are Very Important

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The Company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Plan A

Medicare (Part A) - Hospital Services - Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional lifetime maximum of 365 days -Beyond the additional 365 days	All but \$[1,100] All but \$[275] a day All but \$[550] a day \$[0] \$[0]	\$[0] \$[275] a day \$[550] a day 100% of Medicare eligible expense \$[0]	\$[1,100] (Part A Deductible) \$[0] \$[0] \$[0]** All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[137.50] a day \$[0]	\$[0] \$[0] \$[0]	\$[0] Up to \$[137.50] a day All costs
Blood First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment and coinsurance for outpatient drugs and inpatient respite care	Medicare copayment and coinsurance	\$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan A

Medicare (Part B) - Medical Services - Per Calendar Year

*Once you have been billed \$[155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses – In Or Out Of The Hospital And Outpatient Hospital Treatment , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$[155] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$[0] Generally 80%	\$[0] Generally 20%	\$[155] (Part B Deductible) \$[0]
Part B Excess Charges – Above Medicare-Approved Amounts	\$[0]	\$[0]	All costs
Blood First 3 Pints Next \$[155] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$[0] \$[0] 80%	All costs \$[0] 20%	\$[0] \$[155] (Part B Deductible) \$[0]
Clinical Laboratory Services – Tests For Diagnostic Services	100%	\$[0]	\$[0]

Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
Home Health Care – Medicare-Approved Services -Medically necessary skilled care services and medical supplies -Durable medical equipment: -First \$[155] of Medicare-Approved Amounts* -Remainder of Medicare-Approved Amounts	100% \$[0] 80%	\$[0] \$[0] 20%	\$[0] \$[155] (Part B Deductible) \$[0]

Plan D

Medicare (Part A) - Hospital Services - Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional lifetime maximum of 365 days -Beyond the additional 365 days	All but \$[1,100] All but \$[275] a day All but \$[550] a day \$[0] \$[0]	\$[1,100] (Part A Deductible) \$[275] a day \$[550] a day 100% of Medicare eligible expense \$[0]	\$[0] \$[0] \$[0] \$[0]** All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[137.50] a day \$[0]	\$[0] Up to \$[137.50] a day \$[0]	\$[0] \$[0] All costs
Blood First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment and coinsurance for outpatient drugs and inpatient respite care	Medicare copayment and coinsurance	\$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan D

Medicare (Part B) - Medical Services - Per Calendar Year

*Once you have been billed \$[155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses – In Or Out Of The Hospital And Outpatient Hospital Treatment , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$[155] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$[0] Generally 80%	\$[0] Generally 20%	\$[155] (Part B Deductible) \$[0]
Part B Excess Charges – Above Medicare-Approved Amounts	\$[0]	\$[0]	All costs
Blood First 3 Pints Next \$[155] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$[0] \$[0] 80%	All costs \$[0] 20%	\$[0] \$[155] (Part B Deductible) \$[0]
Clinical Laboratory Services – Tests For Diagnostic Services	100%	\$[0]	\$[0]

Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
Home Health Care – Medicare-Approved Services			
-Medically necessary skilled care services and medical supplies	100%	\$[0]	\$[0]
-Durable medical equipment:			
-First \$[155] of Medicare-Approved Amounts*	\$[0]	\$[0]	\$[155] (Part B Deductible)
-Remainder of Medicare-Approved Amounts	80%	20%	\$[0]

Other Benefits – Not Covered By Medicare

Services	Medicare Pays	Plan Pays	You Pay
Foreign Travel – Not Covered By Medicare			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
-First \$[250] each calendar year	\$[0]	\$[0]	\$[250]
-Remainder of charges	\$[0]	80% to a lifetime maximum benefit of \$[50,000]	20% and amounts over the \$[50,000] lifetime maximum

Plan F

Medicare (Part A) - Hospital Services - Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional lifetime maximum of 365 days -Beyond the additional 365 days	All but \$[1,100] All but \$[275] a day All but \$[550] a day \$[0] \$[0]	\$[1,100] (Part A Deductible) \$[275] a day \$[550] a day 100% of Medicare eligible expense \$[0]	\$[0] \$[0] \$[0] \$[0]** All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[137.50] a day \$[0]	\$[0] Up to \$[137.50] a day \$[0]	\$[0] \$[0] All costs
Blood First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment and coinsurance for outpatient drugs and inpatient respite care	Medicare copayment and coinsurance	\$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan F

Medicare (Part B) - Medical Services - Per Calendar Year

*Once you have been billed \$[155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses – In Or Out Of The Hospital And Outpatient Hospital Treatment , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$[155] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$[0] Generally 80%	\$[155] (Part B Deductible) Generally 20%	\$[0] \$[0]
Part B Excess Charges – Above Medicare-Approved Amounts	\$[0]	100%	\$[0]
Blood First 3 Pints Next \$[155] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$[0] \$[0] 80%	All costs \$[155] (Part B Deductible) 20%	\$[0] \$[0] \$[0]
Clinical Laboratory Services – Tests For Diagnostic Services	100%	\$[0]	\$[0]

Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
Home Health Care – Medicare-Approved Services -Medically necessary skilled care services and medical supplies -Durable medical equipment: -First \$[155] of Medicare-Approved Amounts* -Remainder of Medicare-Approved Amounts	100% \$[0] 80%	\$[0] \$[155] (Part B Deductible) 20%	\$[0] \$[0] \$[0]

Other Benefits – Not Covered By Medicare

Services	Medicare Pays	Plan Pays	You Pay
Foreign Travel – Not Covered By Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA -First \$[250] each calendar year -Remainder of charges	\$[0] \$[0]	\$[0] 80% to a lifetime maximum benefit of \$[50,000]	\$[250] 20% and amounts over the \$[50,000] lifetime maximum

Printed Name of Producer, if any: _____

First	Middle Initial	Last

Address: _____
Street Address, Rural Route or Box Number

City _____ State _____ Zip _____

Phone Number _____ Date _____ Producer/Home Office Employee Signature _____



AUTHORIZATION TO USE AND DISCLOSE PERSONAL INFORMATION

MEANING OF TERMS

Health Care Provider means: all physicians; medical or dental practitioners; hospitals; other health care facilities (including nursing facilities and assisted living facilities); pharmacies; pharmacy benefit managers; the Medical Information Bureau; and any other person or organization that furnishes, bills or is paid for care, services or supplies related to the health of an individual.

Personal Information means: all information about the health of an individual, including medical records in their entirety, information about physical condition and mental condition (excluding psychotherapy notes), prescription drug records and information about drug and alcohol use. Personal Information also includes information about personal finances, occupation, general reputation and insurance claims.

AUTHORIZATION TO DISCLOSE

I authorize any Health Care Provider, government agency, insurance company, insurance agent, employer or consumer reporting agency to disclose Personal Information about me, or my dependent named below, to Medico Insurance Company and to any persons acting on the Company's behalf for the purposes described below.

AUTHORIZATION TO USE

I authorize Medico Insurance Company, or any person or entity employed by the Company, to use the Personal Information covered by this authorization for the purposes described below.

PURPOSES OF DISCLOSURE

Personal Information will be used to determine my and, if applicable, my dependents' eligibility for insurance and to resolve any issues regarding incomplete or incorrect information on my application for insurance that may arise during the processing of the application or in connection with a claim for insurance benefits.

POTENTIAL FOR REDISCLOSURE

The Personal Information used or disclosed based on this authorization may be subject to further disclosure without the protections of federal privacy regulations.

REFUSAL TO SIGN

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, Medico Insurance Company will not accept my application for insurance, and insurance benefits will not be payable.

EXPIRATION AND REVOCATION

This authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time by written notice to: Medico Insurance Company, 1515 South 75th St., Omaha NE 68124-1655.

I understand that my right to revoke this authorization is limited to the extent that the Company has taken action in reliance on the authorization or the law provides the Company with the right to contest a claim under my insurance policy/certificate.

COPY OF THIS AUTHORIZATION

I understand that I will receive a copy of this authorization. A copy of this authorization is as valid as the original.

NAMES AND SIGNATURES

I have received the Notice of Privacy Practices

Printed Name of Applicant/Insured

Signature of Applicant/Insured

Date

If applicable: I am the personal representative of the insured named above whose Personal Information is to be disclosed, and I am authorized to grant permission for disclosure.

Printed Name of Personal Representative

Description of Personal Representative's Authority

Signature of Personal Representative

Date

MEDICO™ INSURANCE COMPANY
Omaha, Nebraska

**LIMITATIONS AND EXCLUSIONS UNDER THE
ARKANSAS LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION ACT**

Residents of this state who purchase life insurance, annuities, or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well-managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
425 W. Capitol Ave.
Suite 3700
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are **NOT** protected by the Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does **NOT** provide coverage for:

- any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends and voting rights and experience rating credits;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals);
- unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution;
- portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 — no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values — again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

MEDICO® INSURANCE COMPANY
1515 SOUTH 75TH STREET
OMAHA, NE 68124

POLICY NUMBER – XXXXXXXX

RIDER PAGE 1 OF 1

TOLL-FREE CLIENT SERVICES

If you have any questions about your policy, you can call this Company's Toll-Free Client Services Line at 1-800-228-6080 between 7:30 A.M. and 4:45 P.M., Monday through Thursday; and 7:30 A.M. and 11:30 A.M. on Friday, Central Time.

If you prefer to write to us, please direct your letter to the Client Services Department, using the Company's name and address shown above.

Questions can also be directed to your producer. (Producer: Attach your business card below.)

In addition, you may submit written inquiries to:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904

You may also call:

Arkansas Insurance Department
Consumer Services Division at
(800) 852-5494 or (501) 371-2640



January 13, 2010

Commissioner Jay Bradford
Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

MEDICO INSURANCE COMPANY
NAIC # 31119

RE: Medicare Supplement Insurance

Enclosed Material:

MI-MSA20A(AR) – Plan A Policy
POLICY A20A – Schedule Page Plan A
MI-MSA20D(AR) – Plan D Policy
POLICY A20D – Schedule Page Plan D
MI-MSA20F(AR) – Plan F Policy
POLICY A20F – Schedule Page Plan F
MI9F-4363(AR) – Outline of Coverage
MIHAA20(AR) – Application
MI9F-4368 – Replacement Notice
MI9F-4367A – Plan A Benefit Change Notice
MI9F-4367D – Plan D Benefit Change Notice
MI9F-4367F – Plan F Benefit Change Notice
Actuarial Memorandum and rate sheets

Previously Approved/Filed Form:

MI9F-2701(AR) -Guaranty Association Notice
MIR-AR-763 –Toll-Free Customer Service Notice

Informational Material

MI9F-4218 – Medical Authorization

SERFF Filing Numbers:

MDIC-126453783 Plan A
MDIC-126453841 Plan D
MDIC-126453857 Plan F

Enclosed for your review are copies of the three Medicare Supplement Policies and accompanying forms for your approval. These new forms will replace forms currently approved by your Department, effective June 1, 2010, due to Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). On May 31, 2010 we will no longer issue our current Medicare Supplement products, and will start issuing the new MIPPA-compliant forms. Changes to the new forms are limited to those specified by MIPPA.

Protecting Your Future Today®

1515 South 75th Street • Omaha, NE 68124 • (402) 391-6900 • fax (402) 391-6489 • claim fax (402) 398-0898 • www.gomedico.com



Page 2

We intend to offer Plans A, D and F through our producers to Medicare eligible individuals. A sample schedule is attached to each policy. Any information contained in the brackets will vary to fit each policyholder. The outline of coverage form MI9F-4363(AR) will be furnished to each applicant as required by state law. The MIHAA20(AR) application will be used by individual applicants to apply for any of the three Plans.

The appropriate benefit change notice will be sent annually to each policyholder residing in the state, no later than 30 days prior to deductible/co-payment changes. I request that the deductible and co-payment amounts found in the outline and benefit change notices be approved as variable to allow updates each year without refiling. I also request that the premium amounts in the outline (although not in brackets due to the vast number of premiums) be approved as variable with the understanding that we will only change these premiums after approval of the rates by your Department.

The MI9F-4368 – Replacement Notice will be used when required by state law.

The Guaranty Association Notice MI9F-2701(AR) will be delivered with the policy. This form received approval by your division on April 21, 2008 under Serff Filing MDIC-125606274 and is enclosed here for informational purposes, only.

The Toll-Free Customer Service Notice, MIR-AR-763 will be delivered with the policy, as required by law. Form MIR-AR-763 was previously approved by your Department on October 27, 2009 under Serff Filing MDIC-126340784. This form is enclosed here for informational purposes only.

The medical authorization MI9F-4218 will be sent with the application to obtain medical authorization from the applicant. This HIPAA Compliant Medical Authorization form is enclosed for informational purposes only.

I thank you in advance for your prompt review and approval of this submission. If you have any questions, please feel free to contact me.

Sincerely,

Luanne Melies
Compliance Analyst
1-800-695-5976 Ext. 249
Fax (402) 391-4858
lmelies@gomedico.com

Protecting Your Future Today®

1515 South 75th Street • Omaha, NE 68124 • (402) 391-6900 • fax (402) 391-6489 • claim fax (402) 398-0898 • www.gomedico.com

<i>SERFF Tracking Number:</i>	<i>MDIC-126453857</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Medico Insurance Company</i>	<i>State Tracking Number:</i>	<i>44561</i>
<i>Company Tracking Number:</i>	<i>AR A20F MIPPA</i>		
<i>TOI:</i>	<i>MS08I Individual Medicare Supplement - Standard Plans 2010</i>	<i>Sub-TOI:</i>	<i>MS08I.005 Plan F (Basic) 2010</i>
<i>Product Name:</i>	<i>AR A20F MIPPA</i>		
<i>Project Name/Number:</i>	<i>AR A20F MIPPA/LM AR A20F MIPPA</i>		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
01/13/2010	Supporting	Application Document	02/09/2010	MIHAA20(AR)-09082009.pdf (Superceded)
02/09/2010	Supporting	Outline of Coverage Document	02/18/2010	MI9F-4363(AR)-B-02042010.pdf (Superceded)
01/13/2010	Supporting	Outline of Coverage Document	02/09/2010	MI9F-4363(AR)-12292009.pdf (Superceded)

Application for Medicare Supplement Insurance

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Part A: General Information – Please Print

Name _____

Date of Birth _____ Age _____ Sex _____ Height _____ Weight _____
 Mo./Day/Yr.

Address _____
 Street Address City State Zip

Phone # _____ E-mail Address _____

Social Security # _____ Medicare Claim # _____

Beneficiary (Optional) _____ Relationship _____

Beneficiary's Address _____
 Street Address City State Zip

Best time to call for Personal Health Interview _____

Are you eligible for Open Enrollment? ☐ Yes ☐ No If "Yes," we will need documentation, unless you are turning 65.

Part B: Insurance Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application.

Please answer the following questions to the best of your knowledge.

1. (a) Did you turn age 65 in the last 6 months? ☐ Yes ☐ No
 (b) Did you enroll in Medicare Part B in the last 6 months? ☐ Yes ☐ No
 (c) If "Yes," what is the effective date? _____
2. Are you insured under Parts A and B of Medicare? (If "No," you are not eligible for coverage) ☐ Yes ☐ No
3. Are you covered for medical assistance through the state Medicaid program? (If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "No" to this question.) ☐ Yes ☐ No
 If "Yes," (a) Will Medicaid pay your premiums for this Medicare supplement policy? ☐ Yes ☐ No
 (b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B Premium? ☐ Yes ☐ No
4. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.
 START _____ END _____
 (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? ☐ Yes ☐ No
 (c) Was this your first time in this type of Medicare plan? ☐ Yes ☐ No
 (d) Did you drop a Medicare supplement policy to enroll in this Medicare plan? ☐ Yes ☐ No
5. (a) Do you have another Medicare supplement policy in force? ☐ Yes ☐ No
 (b) If "Yes," with which company? _____
 what plan? _____

Part B: Insurance Information (continued)

(c) If so, do you intend to replace your current Medicare supplement policy with this policy? ☐ Yes ☐ No

PRODUCER: If the answer to this question is yes, please complete and submit NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE.

6. Have you had coverage under any other health insurance within the past 63 days?
(For example, an employer, union or individual plan.) ☐ Yes ☐ No

(a) If "Yes," with which company? _____
what kind of policy? _____

(b) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.)

START _____ END _____

7. If you have lost or are losing other health insurance coverage, have you provided a copy of the notice from your prior insurer? ☐ Yes ☐ No

If "No," please provide an explanation. _____

Producer shall list any other health insurance policies he/she has sold to the applicant.

1) List policies you sold to the applicant that are still in force (If none, indicate "None"): ☐ None

Name of Insurer	Type	Policy #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2) List policies you sold to the applicant in the past five (5) years that are no longer in force (If none, indicate "None"): ☐ None

Name of Insurer	Type	Policy #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Producer: Is the insurance applied for intended to replace any medical or health insurance coverage? ☐ Yes ☐ No

Part C: Medical Information

NOTE: These questions should not be answered if you apply during "Open Enrollment" or if you are eligible for a guaranteed issue. If you answer "Yes," to any of questions 1 through 4 you are not eligible for coverage.

1. Have you ever:

(a) had any fractures due to osteoporosis or amputation due to disease? ☐ Yes ☐ No

(b) had kidney disease requiring dialysis; diabetes requiring insulin; Parkinson's disease; liver disease; or multiple or lateral sclerosis? ☐ Yes ☐ No

(c) been diagnosed with emphysema; chronic obstructive pulmonary disorder (COPD); or any other chronic pulmonary disorder? ☐ Yes ☐ No

(d) been treated for Alzheimer's disease; senile dementia; or organic brain disorder? ☐ Yes ☐ No

(e) had an organ transplant or been advised by a physician to have an organ transplant? ☐ Yes ☐ No

(f) had or been treated for Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No

Part C: Medical Information, continued

2. Within the past 24 months have you:

- (a) been hospitalized 3 or more times? ☐ Yes ☐ No
- (b) had a stroke or transient ischemic attack (TIA)? ☐ Yes ☐ No
- (c) been treated for or been diagnosed as having internal cancer; leukemia; or malignant melanoma? ☐ Yes ☐ No
- (d) had heart trouble or disease that required treatment by a physician (not including high blood pressure)? Taking prescription medication is not considered treatment. ☐ Yes ☐ No
- (e) been treated for alcohol or drug abuse; degenerative bone disease; crippling or rheumatoid arthritis; or been advised by a physician to have a joint replacement? ☐ Yes ☐ No

3. Within the past 12 months have you been advised that surgery for cataracts may be required? ☐ Yes ☐ No

4. Currently:

- (a) are you bedridden; confined (or has any doctor recommended that you be confined) to a hospital or nursing facility; or do you need the assistance of a walker or wheelchair? ☐ Yes ☐ No
- (b) do you have surgery pending or have you been advised to have surgery? ☐ Yes ☐ No

5. List all medications taken within the past 12 months (if none, indicate none).

Please provide the following information:

Medication				
Date originally prescribed				
Frequency and dosage				
Diagnosis/condition				

Part D: Preferred Rate Information

NOTE: This question should not be answered if you apply during "Open Enrollment" or if you are eligible for a guaranteed issue.

To qualify for preferred rates you must be able to answer "No" to the following question:

Have you used tobacco in the past 12 months? ☐ Yes ☐ No

Part E: Notices

You do not need more than one Medicare supplement policy.

If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility.

If you are eligible for, and have enrolled in, a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan.

Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

Part F: Benefit Options – Check the Plan you prefer:

☐ Policy Form MSA20A – Plan A

☐ Policy Form MSA20D – Plan D

☐ Policy Form MSA20F – Plan F

Make all checks payable to: Medico Insurance Company (do not make checks payable to the producer or leave payee line blank).

Note: If you select the Automatic Bank Withdrawal method of payment and we receive no money with your application, your first premium will be withdrawn from your bank account on the day we issue your policy.

Method of Payment:

☐ Automatic Bank Withdrawal

☐ Direct Bill

Frequency of Payment:

☐ Monthly

☐ Bi-Monthly

☐ Quarterly

☐ Bi-Monthly

☐ Quarterly

☐ Semi-Annually

☐ Annually

Amount Received with Application \$ _____

Renewal Premium \$ _____

Effective Date of Policy _____
(Day after applicant signs the application or expiration date of current policy)

If you currently have health insurance in force, on what date does it end? _____

Part G: Application Agreement

I hereby apply for insurance to be issued solely and entirely upon the answers and statements in the Parts above that I adopt as my own and represent to be true, full and complete. I understand and agree that no insurance will be in force until coverage has been issued. If I am not applying during "Open Enrollment" or not eligible for a guaranteed issue, I do not have a right to have this policy issued to me if I have answered "Yes" to any of questions 1 through 4 in the Medical Information Part above. I have read, or had read to me, the complete application.

I have received the Notice of Privacy Practices and the Outline of Coverage for the policy.

Check one of the following if "A Guide to Health Insurance for People With Medicare" is required in the applicants' state:

- ☐ 1. I have agreed to accept a link to the Medicare Buyers Guide on the Company website at www.gomedico.com/products.
- ☐ 2. I have received a hard copy of the Medicare Buyers Guide.

I understand that it may be necessary to phone me to verify the answers to the questions in this application.

CAUTION: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or if the misrepresentation was material to our acceptance of the risk, rescind your policy.

Applicant's Signature _____ Date _____

Dated at _____
City State

Producer's Name _____
(Please print)

Producer's Signature _____ Date _____

Outline of Medicare Supplement Coverage – Benefit Plans A, D, and F

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

[Plans E, H, I and J are no longer available for sale.]

Basic Benefits:

- **Hospitalization** – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses** – Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood** – First three pints of blood each year.
- **Hospice** – Part A coinsurance.

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*		Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket \$[4620]; paid at 100% after limit reached	Out-of-pocket \$[2310]; paid at 100% after limit reached		

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [\$2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

PREMIUMS FOR MEDICARE SUPPLEMENT INSURANCE POLICY SERIES A20 – PLANS A, D AND F

Zip Codes: 716, 720, 721, 722 and 723

Issue Age	Preferred			Standard		
	Plan A	Plan D	Plan F	Plan A	Plan D	Plan F
65 & Over	\$1,147.97	\$1,593.02	\$1,713.98	\$1,319.42	\$1,831.10	\$1,970.11

Zip Codes: 717, 718, 719, 724, 725, 726, 727, 728 and 729

Issue Age	Preferred			Standard		
	Plan A	Plan D	Plan F	Plan A	Plan D	Plan F
65 & Over	\$1,018.82	\$1,413.81	\$1,521.16	\$1,170.99	\$1,625.10	\$1,748.47

*Premium rates shown above were approved in Arkansas on [July 1, 2009].

Premiums payable other than annual may be determined by the following factors:

	<u>[Monthly]</u>	<u>[Quarterly]</u>	<u>[Semi-Annual]</u>
[Automatic Bank Withdrawal:	1/12	0.25	N/A]
[Direct-Billed:	N/A	0.27	0.52]
[Credit/Debit Card:	1/12	0.27	0.52]

Premium Information

We, Medico Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this state.

Disclosures

Use this outline to compare benefits and premiums among policies.

[This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010, have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.]

Read Your Policy Very Carefully

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

Right To Return Policy

If you find that you are not satisfied with your policy, you may return it to 1515 South 75th Street, Omaha, NE 68124. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

Policy Replacement

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

Notice

This policy may not fully cover all of your medical costs.

Neither Medico Insurance Company nor its producers are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "The Medicare Handbook" for more details.

Complete Answers Are Very Important

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The Company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Plan A

Medicare (Part A) - Hospital Services - Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional lifetime maximum of 365 days -Beyond the additional 365 days	All but \$[1,100] All but \$[275] a day All but \$[550] a day \$[0] \$[0]	\$[0] \$[275] a day \$[550] a day 100% of Medicare eligible expense \$[0]	\$[1,100] (Part A Deductible) \$[0] \$[0] \$[0]** All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[137.50] a day \$[0]	\$[0] \$[0] \$[0]	\$[0] Up to \$[137.50] a day All costs
Blood First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment and coinsurance for outpatient drugs and inpatient respite care	Medicare copayment and coinsurance	\$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan A

Medicare (Part B) - Medical Services - Per Calendar Year

*Once you have been billed \$[155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses – In Or Out Of The Hospital And Outpatient Hospital Treatment , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$[155] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$[0] Generally 80%	\$[0] Generally 20%	\$[155] (Part B Deductible) \$[0]
Part B Excess Charges – Above Medicare-Approved Amounts	\$[0]	\$[0]	All costs
Blood First 3 Pints Next \$[155] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$[0] \$[0] 80%	All costs \$[0] 20%	\$[0] \$[155] (Part B Deductible) \$[0]
Clinical Laboratory Services – Tests For Diagnostic Services	100%	\$[0]	\$[0]

Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
Home Health Care – Medicare-Approved Services -Medically necessary skilled care services and medical supplies -Durable medical equipment: -First \$[155] of Medicare-Approved Amounts* -Remainder of Medicare-Approved Amounts	100% \$[0] 80%	\$[0] \$[0] 20%	\$[0] \$[155] (Part B Deductible) \$[0]

Plan D

Medicare (Part A) - Hospital Services - Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional lifetime maximum of 365 days -Beyond the additional 365 days	All but \$[1,100] All but \$[275] a day All but \$[550] a day \$[0] \$[0]	\$[1,100] (Part A Deductible) \$[275] a day \$[550] a day 100% of Medicare eligible expense \$[0]	\$[0] \$[0] \$[0] \$[0]** All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[137.50] a day \$[0]	\$[0] Up to \$[137.50] a day \$[0]	\$[0] \$[0] All costs
Blood First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment and coinsurance for outpatient drugs and inpatient respite care	Medicare copayment and coinsurance	\$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan D

Medicare (Part B) - Medical Services - Per Calendar Year

*Once you have been billed \$[155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses – In Or Out Of The Hospital And Outpatient Hospital Treatment , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$[155] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$[0] Generally 80%	\$[0] Generally 20%	\$[155] (Part B Deductible) \$[0]
Part B Excess Charges – Above Medicare-Approved Amounts	\$[0]	\$[0]	All costs
Blood First 3 Pints Next \$[155] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$[0] \$[0] 80%	All costs \$[0] 20%	\$[0] \$[155] (Part B Deductible) \$[0]
Clinical Laboratory Services – Tests For Diagnostic Services	100%	\$[0]	\$[0]

Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
Home Health Care – Medicare-Approved Services			
-Medically necessary skilled care services and medical supplies	100%	\$[0]	\$[0]
-Durable medical equipment:			
-First \$[155] of Medicare-Approved Amounts*	\$[0]	\$[0]	\$[155] (Part B Deductible)
-Remainder of Medicare-Approved Amounts	80%	20%	\$[0]

Other Benefits – Not Covered By Medicare

Services	Medicare Pays	Plan Pays	You Pay
Foreign Travel – Not Covered By Medicare			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
-First \$[250] each calendar year	\$[0]	\$[0]	\$[250]
-Remainder of charges	\$[0]	80% to a lifetime maximum benefit of \$[50,000]	20% and amounts over the \$[50,000] lifetime maximum

Plan F

Medicare (Part A) - Hospital Services - Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional lifetime maximum of 365 days -Beyond the additional 365 days	All but \$[1,100] All but \$[275] a day All but \$[550] a day \$[0] \$[0]	\$[1,100] (Part A Deductible) \$[275] a day \$[550] a day 100% of Medicare eligible expense \$[0]	\$[0] \$[0] \$[0] \$[0]** All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[137.50] a day \$[0]	\$[0] Up to \$[137.50] a day \$[0]	\$[0] \$[0] All costs
Blood First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment and coinsurance for outpatient drugs and inpatient respite care	Medicare copayment and coinsurance	\$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan F

Medicare (Part B) - Medical Services - Per Calendar Year

*Once you have been billed \$[155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses – In Or Out Of The Hospital And Outpatient Hospital Treatment , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$[155] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$[0] Generally 80%	\$[155] (Part B Deductible) Generally 20%	\$[0] \$[0]
Part B Excess Charges – Above Medicare-Approved Amounts	\$[0]	100%	\$[0]
Blood First 3 Pints Next \$[155] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$[0] \$[0] 80%	All costs \$[155] (Part B Deductible) 20%	\$[0] \$[0] \$[0]
Clinical Laboratory Services – Tests For Diagnostic Services	100%	\$[0]	\$[0]

Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
Home Health Care – Medicare-Approved Services -Medically necessary skilled care services and medical supplies -Durable medical equipment: -First \$[155] of Medicare-Approved Amounts* -Remainder of Medicare-Approved Amounts	100% \$[0] 80%	\$[0] \$[155] (Part B Deductible) 20%	\$[0] \$[0] \$[0]

Other Benefits – Not Covered By Medicare

Services	Medicare Pays	Plan Pays	You Pay
Foreign Travel – Not Covered By Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA -First \$[250] each calendar year -Remainder of charges	\$[0] \$[0]	\$[0] 80% to a lifetime maximum benefit of \$[50,000]	\$[250] 20% and amounts over the \$[50,000] lifetime maximum

Printed Name of Producer, if any: _____

First	Middle Initial	Last

Address: _____
Street Address, Rural Route or Box Number

City _____ State _____ Zip _____

Phone Number _____ Date _____ Producer/Home Office Employee Signature _____

Outline of Medicare Supplement Coverage – Benefit Plans A, D, and F

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

[Plans E, H, I and J are no longer available for sale.]

Basic Benefits:

- **Hospitalization** – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses** – Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood** – First three pints of blood each year.
- **Hospice** – Part A coinsurance.

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*		Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket \$[4620]; paid at 100% after limit reached	Out-of-pocket \$[2310]; paid at 100% after limit reached		

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [\$2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

PREMIUMS FOR MEDICARE SUPPLEMENT INSURANCE POLICY SERIES A10 – PLANS A, D AND F

Zip Codes: 716, 720, 721, 722 and 723

Issue Age	Preferred			Standard		
	Plan A	Plan D	Plan F	Plan A	Plan D	Plan F
65 & Over	\$1,147.97	\$1,593.02	\$1,713.98	\$1,319.42	\$1,831.10	\$1,970.11

Zip Codes: 717, 718, 719, 724, 725, 726, 727, 728 and 729

Issue Age	Preferred			Standard		
	Plan A	Plan D	Plan F	Plan A	Plan D	Plan F
65 & Over	\$1,018.82	\$1,413.81	\$1,521.16	\$1,170.99	\$1,625.10	\$1,748.47

*Premium rates shown above were approved in Arkansas on July 1, 2009.

Premiums payable other than annual may be determined by the following factors:

	<u>Monthly</u>	<u>Bi-Monthly</u>	<u>Quarterly</u>	<u>Semi-Annual</u>
Automatic Bank Withdrawal:	1/12	2/12	0.25	0.52
Direct-Billed:	1/11	2/11	0.27	0.52

Premium Information

We, Medico Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this state.

Disclosures

Use this outline to compare benefits and premiums among policies.

[This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010, have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.]

Read Your Policy Very Carefully

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

Right To Return Policy

If you find that you are not satisfied with your policy, you may return it to 1515 South 75th Street, Omaha, NE 68124. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

Policy Replacement

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

Notice

This policy may not fully cover all of your medical costs.

Neither Medico Insurance Company nor its producers are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "The Medicare Handbook" for more details.

Complete Answers Are Very Important

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The Company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Plan A

Medicare (Part A) - Hospital Services - Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional lifetime maximum of 365 days -Beyond the additional 365 days	All but \$[1,100] All but \$[275] a day All but \$[550] a day \$[0] \$[0]	\$[0] \$[275] a day \$[550] a day 100% of Medicare eligible expense \$[0]	\$[1,100] (Part A Deductible) \$[0] \$[0] \$[0]** All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[137.50] a day \$[0]	\$[0] \$[0] \$[0]	\$[0] Up to \$[137.50] a day All costs
Blood First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment and coinsurance for outpatient drugs and inpatient respite care	Medicare copayment and coinsurance	\$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan A

Medicare (Part B) - Medical Services - Per Calendar Year

*Once you have been billed \$[155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses – In Or Out Of The Hospital And Outpatient Hospital Treatment , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$[155] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$[0] Generally 80%	\$[0] Generally 20%	\$[155] (Part B Deductible) \$[0]
Part B Excess Charges – Above Medicare-Approved Amounts	\$[0]	\$[0]	All costs
Blood First 3 Pints Next \$[155] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$[0] \$[0] 80%	All costs \$[0] 20%	\$[0] \$[155] (Part B Deductible) \$[0]
Clinical Laboratory Services – Tests For Diagnostic Services	100%	\$[0]	\$[0]

Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
Home Health Care – Medicare-Approved Services -Medically necessary skilled care services and medical supplies -Durable medical equipment: -First \$[155] of Medicare-Approved Amounts* -Remainder of Medicare-Approved Amounts	100% \$[0] 80%	\$[0] \$[0] 20%	\$[0] \$[155] (Part B Deductible) \$[0]

Plan D

Medicare (Part A) - Hospital Services - Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional lifetime maximum of 365 days -Beyond the additional 365 days	All but \$[1,100] All but \$[275] a day All but \$[550] a day \$[0] \$[0]	\$[1,100] (Part A Deductible) \$[275] a day \$[550] a day 100% of Medicare eligible expense \$[0]	\$[0] \$[0] \$[0] \$[0]** All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[137.50] a day \$[0]	\$[0] Up to \$[137.50] a day \$[0]	\$[0] \$[0] All costs
Blood First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment and coinsurance for outpatient drugs and inpatient respite care	Medicare copayment and coinsurance	\$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan D

Medicare (Part B) - Medical Services - Per Calendar Year

*Once you have been billed \$[155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses – In Or Out Of The Hospital And Outpatient Hospital Treatment , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$[155] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$[0] Generally 80%	\$[0] Generally 20%	\$[155] (Part B Deductible) \$[0]
Part B Excess Charges – Above Medicare-Approved Amounts	\$[0]	\$[0]	All costs
Blood First 3 Pints Next \$[155] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$[0] \$[0] 80%	All costs \$[0] 20%	\$[0] \$[155] (Part B Deductible) \$[0]
Clinical Laboratory Services – Tests For Diagnostic Services	100%	\$[0]	\$[0]

Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
Home Health Care – Medicare-Approved Services			
-Medically necessary skilled care services and medical supplies	100%	\$[0]	\$[0]
-Durable medical equipment:			
-First \$[155] of Medicare-Approved Amounts*	\$[0]	\$[0]	\$[155] (Part B Deductible)
-Remainder of Medicare-Approved Amounts	80%	20%	\$[0]

Other Benefits – Not Covered By Medicare

Services	Medicare Pays	Plan Pays	You Pay
Foreign Travel – Not Covered By Medicare			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
-First \$[250] each calendar year	\$[0]	\$[0]	\$[250]
-Remainder of charges	\$[0]	80% to a lifetime maximum benefit of \$[50,000]	20% and amounts over the \$[50,000] lifetime maximum

Plan F

Medicare (Part A) - Hospital Services - Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional lifetime maximum of 365 days -Beyond the additional 365 days	All but \$[1,100] All but \$[275] a day All but \$[550] a day \$[0] \$[0]	\$[1,100] (Part A Deductible) \$[275] a day \$[550] a day 100% of Medicare eligible expense \$[0]	\$[0] \$[0] \$[0] \$[0]** All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[137.50] a day \$[0]	\$[0] Up to \$[137.50] a day \$[0]	\$[0] \$[0] All costs
Blood First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment and coinsurance for outpatient drugs and inpatient respite care	Medicare copayment and coinsurance	\$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan F

Medicare (Part B) - Medical Services - Per Calendar Year

*Once you have been billed \$[155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses – In Or Out Of The Hospital And Outpatient Hospital Treatment , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$[155] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$[0] Generally 80%	\$[155] (Part B Deductible) Generally 20%	\$[0] \$[0]
Part B Excess Charges – Above Medicare-Approved Amounts	\$[0]	100%	\$[0]
Blood First 3 Pints Next \$[155] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$[0] \$[0] 80%	All costs \$[155] (Part B Deductible) 20%	\$[0] \$[0] \$[0]
Clinical Laboratory Services – Tests For Diagnostic Services	100%	\$[0]	\$[0]

Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
Home Health Care – Medicare-Approved Services -Medically necessary skilled care services and medical supplies -Durable medical equipment: -First \$[155] of Medicare-Approved Amounts* -Remainder of Medicare-Approved Amounts	100% \$[0] 80%	\$[0] \$[155] (Part B Deductible) 20%	\$[0] \$[0] \$[0]

Other Benefits – Not Covered By Medicare

Services	Medicare Pays	Plan Pays	You Pay
Foreign Travel – Not Covered By Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA -First \$[250] each calendar year -Remainder of charges	\$[0] \$[0]	\$[0] 80% to a lifetime maximum benefit of \$[50,000]	\$[250] 20% and amounts over the \$[50,000] lifetime maximum

Printed Name of Producer, if any: _____

First	Middle Initial	Last

Address: _____
Street Address, Rural Route or Box Number

City _____ State _____ Zip _____

Phone Number _____ Date _____ Producer/Home Office Employee Signature _____